

CHAMPVA POLICY MANUAL

CHAPTER 3
SECTION 6.3
TITLE: COST-TO-CHARGE (CTC) PAYMENT SYSTEM

AUTHORITY: 38 CFR 17.270(a), 17.272(b) and 17.274

RELATED AUTHORITY: 32 CFR 199.14(a)(1)

I. EFFECTIVE DATE

October 8, 1987

II. DESCRIPTION

The cost-to-charge payment system is used to determine the allowable cost for inpatient care furnished by a hospital or a facility not covered by the DRG-based prospective payment system or the inpatient mental health per diem payment system. This payment system is also applicable to hospital stays that are exempt from the DRG-based payment system based on diagnosis. The current cost-to-charge rate is 100 percent of the billed charge.

III. POLICY

A. Health Facilities Covered by Cost-To-Charge (CTC). The following hospitals are considered exempt, or excluded from the DRG-based payment system and per diem payment system. These hospitals are subject to the CTC (billed charge) payment methodology:

1. Cancer hospitals. Any hospital that qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare Prospective Payment System (PPS) is exempt from the DRG-based payment system.
2. Christian Science sanatoriums.
3. Foreign hospitals. Any hospital outside the 50 states, the District of Columbia, or Puerto Rico.
4. Long-term hospitals.
5. Non-Medicare participating hospitals.

6. Non-VA Federal Health Care Facilities (military treatment facilities, Indian Health Service).

7. Rehabilitation hospitals.

Note: Within this policy, rehabilitation hospitals do not include substance use disorder rehabilitation facilities (SUDRF) or psychiatric and substance use disorder rehabilitation partial hospitalization. [32 CFR 199.14]

8. Skilled Nursing Facilities (SNFs).

9. Sole community hospitals. Any hospital that has qualified for special treatment under the Medicare PPS as a sole community hospital and has not given up that classification is exempt from the DRG-based payment system.

10. State waivers. Any state that has implemented a separate DRG-based payment system or similar payment system in order to control costs **for inpatient care may be exempt from the CHAMPVA DRG-based payment system.** The only state currently exempt is Maryland. Inpatient services provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since Maryland hospitals are required to bill these rates, CHAMPVA reimbursement for **inpatient services are** to be based on the billed charge. **Reimbursement for all outpatient and professional provider services will be based on the CHAMPVA maximum allowable charge (CMAC) (see [Chapter 3, Section 5.1, Outpatient and Inpatient Professional Provider Reimbursement](#)).**

B. Services Covered by Cost-To-Charge. The following hospital services, even when provided in a hospital subject to the DRG-based payment system, are considered exempt and are subject to the cost-to-charge payment system.

1. Solid organ acquisition, i.e., kidney, heart, lung, including donor inpatient stay, is paid on a reasonable cost basis and is not included in the DRG.

2. All services related to pancreas transplant alone (PTA), simultaneous pancreas-kidney (SPK) and pancreas after kidney (PAK) through September 30, 1999. Effective October 1, 1999, PTA, SPK, and PAK will be paid under the appropriate DRG. Acquisition costs will continue to be paid on a reasonable cost basis and are not included in the DRG.

3. Heart, heart-lung, and liver transplantation through September 30, 1998. Effective October 1, 1998, heart and heart-lung transplants are paid under DRG 103 and liver transplants are paid under DRG 480. Acquisition costs related to these transplants will continue to be paid on a reasonable cost basis and are not included in the DRG.

4. Lung transplantation through September 30, 1994. Effective October 1, 1994, lung transplants are paid under DRG 495. Acquisition costs related to the lung will continue to be paid on a reasonable cost basis and are not included in the DRG.

5. All services related to small intestine, combined small intestine/liver and multivisceral transplants through September 30, 2001. Effective October 1, 2001, these transplants shall be paid under the appropriate DRG. Acquisition costs related to these transplants shall continue to be paid on a reasonable cost basis and are not included in the DRG.

6. Pediatric bone marrow transplantation for patients under 18 years of age on the date of admission. (ICD-9-CM diagnosis codes V42.4 and ICD-9 procedure codes 41.00 - 41.09 and 41.91.)

7. HIV seropositive admissions for patients under 18 years of age on the date of admission. (ICD-9-CM diagnosis codes 042, 079.53, and 795.71.)

8. Pediatric cystic fibrosis admissions for patients under 18 years of age on the date of admission. (ICD-9-CM diagnosis codes 277.0, 277.00 277.01, 277.02, 277.03, and 277.09.)

9. Outpatient hospital services related to inpatient stays.

10. Blood clotting factor for hemophilia inpatients.

a. For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a patient who is a hemophiliac. Payment will be made for blood clotting factor when one of the following hemophilia ICD-9-CM diagnosis codes is listed on the claim:

286.0 Congenital Factor VIII Disorder,
286.1 Congenital Factor IX Disorder,
286.2 Congenital Factor XI Deficiency,
286.3 Congenital Deficiency of Other Clotting Factors,
286.4 Von Willebrand's Disease,
286.5 Hemorrhagic Disorder Due to Circulating Anticoagulants, and
286.7 Acquired Coagulation Factor Deficiency.

b. For admissions occurring on or after October 1, 1994, and prior to admissions occurring on or after October 1, 1997, the cost of blood clotting factor for hemophilia inpatients is no longer eligible for separate reimbursement.

c. Payment rates for each unit of blood clotting factor have been established as indicated below.

(1) For admissions occurring on or after October 1, 1997, through September 30, 1998:

Factor VIII (antihemophilic factor-human) - \$.76 per unit
Factor VIII (antihemophilic factor-recombinant) - \$ 1.00 per unit
Factor IX (complex) - \$.32 per unit
Other Hemophilia clotting factors (i.e. anti-inhibitors) - \$1.10 per unit

(2) For admissions occurring on or after June 11, 1998, through September 30, 1998, the following payment rates shall be used for purified Factor IX products:

Factor IX (antihemophilic factor-nonrecombinant) - \$.93 per unit
Factor IX (antihemophilic factor-recombinant) - \$1.00 per unit

(3) For admissions occurring on or after October 1, 1998, through September 30, 1999:

Factor VIII (antihemophilic factor-human) - \$0.78 per unit
Factor VIII (antihemophilic factor-recombinant) - \$1.00 per unit
Factor IX (complex) - \$0.38 per unit
Other Hemophilia clotting factors (i.e., anti-inhibitors) - \$1.10 per unit

Factor IX (antihemophilic factor, nonrecombinant) - \$0.93 per unit
Factor IX (antihemophilic factor, recombinant) - \$1.00 per unit

(4) For admissions occurring on or after October 1, 1999 through September 30, 2000:

Factor VIII (antihemophilic factor-human) - \$0.79 per unit
Factor VIII (antihemophilic factor, porcine) - \$1.87 per unit
Factor VIII (antihemophilic factor-recombinant) - \$1.03 per unit
Factor IX (complex) - \$0.45 per unit
Other Hemophilia clotting factors (e.g., anti-inhibitors) \$1.43 per unit

Factor IX (antihemophilic factor, nonrecombinant) - \$0.97 per unit
Factor IX (antihemophilic factor, recombinant) - \$1.00 per unit

(5) Payment rates for each unit of blood clotting factor for FY01 and subsequent years are included with the procedure codes referenced.

d. Procedure codes for billing blood-clotting factors have been established as follows.

(1) For admissions occurring on or after October 1, 1997, through September 30, 1998, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor:

Factor VIII (antihemophilic factor-human) - J7190
Factor VIII (antihemophilic factor-recombinant) - J7192
Factor IX (complex) - J7194
All other factors - J7196

(2) For admissions occurring on or after June 11, 1998, through September 30, 1998, hospitals will use the following new HCPCS billing codes for purified Factor IX products:

Factor IX (antihemophilic factor, nonrecombinant) - Q0160
Factor IX (antihemophilic factor-recombinant) - Q0161

(3) For admissions occurring on or after October 1, 1998, through September 30, 1999, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor:

Factor VIII (antihemophilic factor-human) - J7190
Factor VIII (antihemophilic factor-recombinant) - J7192
Factor IX (complex) - J7194
Other Hemophilia clotting factors (i.e., anti-inhibitors) - J7196
Factor IX (antihemophilic factor, nonrecombinant) - Q0160
Factor IX (antihemophilic factor, recombinant) - Q0161

(4) For admissions occurring on or after October 1, 1999, through September 30, 2000, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor:

Factor VIII (antihemophilic factor-human) - J7190
Factor VIII (antihemophilic factor, porcine) - J7191
Factor VIII (antihemophilic factor, recombinant) - J7192
Factor IX (complex) - J7194
Other Hemophilia clotting factors (e.g., anti-inhibitors) - J7196
Antithrombin III (human) - J7197
Hemophilia clotting factor, not otherwise classified - J7199
Factor IX (antihemophilic factor, nonrecombinant) - Q0160
Factor IX (antihemophilic factor, recombinant) - Q0161

(5) Each unit billed on the hospital claim represents 100 payment units. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be \$1,600 (paid at \$.64/unit - Factor VIII).

Note: The costs of blood clotting factor are reimbursed separately for admissions occurring on or after October 1, 1997. For these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factors are to be included when calculating the cost share base on billed charges.

(6) For admissions occurring on or after October 1, 2000, through September 30, 2001, the following HCPCS codes and payment rates will be used to bill for blood clotting factors:

	J7190 Factor VIII (antihemophilic factor - human) \$0.85 per unit
	J7191 Factor VIII (antihemophilic factor - porcine) \$2.09 per unit
unit	J7192 Factor VIII (antihemophilic factor - recombinant) \$1.12 per
	J7194 Factor IX (complex) \$0.31 per unit
	J7198 Anti-inhibitor \$ 1.43 per unit
\$1.05 per unit.	Q0160 Factor IX (antihemophilic factor, purified, non-recombinant)
unit	Q0161 Factor IX (antihemophilic factor, recombinant) \$1.12 per

Note: HCPCS billing code J7198 replaces code J7196 (other hemophilia clotting factors (e.g., anti-inhibitors)).

(7) For admissions occurring on or after October 1, 2001, through September 30, 2002, the following HCPCS codes and payment rates shall be used for blood clotting factors:

	J7190 Factor VIII (antihemophilic factor - human) \$0.86 per unit
	J7191 Factor VIII (antihemophilic factor - porcine) \$2.09 per unit
unit	J7192 Factor VIII (antihemophilic factor - recombinant) \$1.12 per
	J7194 Factor IX (complex) \$0.31 per unit
	J7198 Anti-inhibitor \$1.43 per unit
non-recombinant) \$1.05 per unit	Q0160 Factor IX (antihemophilic factor, purified,
unit	Q0161 Factor IX (antihemophilic factor, recombinant) \$1.12 per

(8) For admissions occurring on or after October 1, 2002, through September 30, 2003, the following HCPCS codes and payment rates shall be used for blood clotting factors:

	J7190 Factor VIII (antihemophilic factor - human) \$0.86 per unit
	J7191 Factor VIII (antihemophilic factor - porcine) \$2.04 per unit
unit	J7192 Factor VIII (antihemophilic factor - recombinant) \$1.24 per

\$1.05 J7193 Factor IX (antihemophilic factor, purified – non-recombinant,
unit J7194 Factor IX (complex) \$0.33 per unit
J7195 Factor IX (antihemophilic factor – recombinant) \$1.12 per
unit J7198 Anti-Inhibitor \$1.43
J7199 Hemophilia Clotting Factor, not otherwise classified (the
provider must report the name of the drug and how the drug is dispensed in the remarks
section of the claim)
Q0187 Factor VIIa (coagulation factor – recombinant) billing unit
per 1.2 mg \$1,596 per unit
Q2022 Von Willebrand Factor (complex-human) \$0.95 per unit

IV. POLICY CONSIDERATIONS

A. Under the cost-to-charge payment system calculation, the beneficiary inpatient cost share is 25 percent of the allowable amount (billed amount less any noncovered service or item). For covered services, beneficiaries are not responsible for amounts that exceed the CHAMPVA allowable.

B. Beneficiary Eligibility.

a. If the beneficiary is a patient in a non-DRG medical facility, the allowable costs through the day on which the beneficiary loses eligibility will be paid.

b. If the beneficiary gains eligibility while hospitalized in a non-DRG medical facility, the medical costs beginning with the day eligibility is effective will be paid.

C. Beneficiary submitted claims. All inpatient claims will be paid to the provider regardless of whether the beneficiary specifically requests payment.

D. Leave of Absence Days. In billing for inpatient stays, which include leave of absence, medical facilities are to use the actual admission and discharge dates and are to identify all leave of absence days. Leave of absence days are disallowed and neither CHAMPVA nor the beneficiary may be billed for days of leave.

E. Other Health Insurance (OHI). The OHI criterion applies to the cost-to-charge payment system. CHAMPVA is always the secondary payer of benefits when there is OHI except when the beneficiary has entitlement to Medicaid, State Victims of Crime Compensation programs, and CHAMPVA supplemental insurance. Payment of benefits may not be extended until all other double coverage plans or other health insurance has adjudicated the claim.

END OF POLICY